STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		D SERVICES  R/SUPPLIER/CLIA  ATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION ()	OMB NO. 0938-( COMPLETED
		445303	B. WING		
NORRIS HEALTH AND	REHABILITATION C		33	EET ADDRESS, CITY, STATE, ZIP CODE 82 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705	05/25/2011
THEFIX (CACH DEF	ARY STATEMENT OF DEF ICIENCY MUST BE PREC RY OR LSC IDENTIFYING	EDED DV E	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLET
F 157 483.10(b)(11 SS=D (INJURY/DE	CLINE/ROOM, ETC	)	F 157	F157	6/24
known, notify or an interested accident involvinjury and has intervention; a physical, mendeterioration in status in either clinical complising significantly (i. existing form of consequences treatment); or the resident from \$483.12(a).  The facility must and, if known, the or interested factor in specified in \$480.  The facility must regulations as set this section.  The facility must he address and legal representations.  This REQUIREM by: Based on medicine.	t immediately inform the resident's physic the resident's legal and family member with the potential for redissignificant change tal, or psychosocial in health, mental, or life threatening concations); a need to a set, a need to disconfi treatment due to a commence and decision to transfer the facility as specified in paragraph to record and periodic phone number of the tive or interested family met as a facility as specified in paragraph to the resident's legal record and periodic phone number of the tive or interested family met as a facility as specified in paragraph to the resident's legal record and periodic phone number of the tive or interested family met as a facility as	ian; and if representative when there is an nich results in quiring physician in the resident's status (i.e., a psychosocial nditions or alter treatment tinue an adverse new form of er or discharge ecified in  ify the resident representative there is a pnment as ange in ate law or oh (b)(1) of  cally update he resident's mily member.		HOW WILL CORRECTIVE ACT BE ACCOMPLISHED FOR THO RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE?  Resident #14 had her J tube replaced after the MD was notified on 5/24/1 Resident was taking PO diet as well.  Resident #14 is no longer at this facility IDENTIFY OTHER RESIDENT SHAVING THE POTENTIAL TO AFFECTED BY THE SAME DEFICIENT PRACTICE?  All residents with enteral feedings had the Potential to be affected.  The facility identified 12 residents the have enteral feedings.  Those residents identified with enter feedings were assessed on May 25, 2 and again on June 6, 2011 to ensure tubes were patent.	d 1

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEL AID SERVICES

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(2/2)		OMB N	O. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF	000//055	445303	B. WING			· · _ · · · · · · · · · · · · · · ·
	PROVIDER OR SUPPLIER HEALTH AND REHAI	BILITATION CENTER	1	TREET ADDRESS, CITY, STATE, ZIP COD 3382 ANDERSONVILLE HIGHWAY	05/ E	25/2011
(X4) ID PREFIX TAG	(STOP DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AI  DEFICIENCY)	HOLLDE	(X5) COMPLETION DATE
Me da "	The findings include Resident #14 was ad 12, 2011, with diagnostenosis, Hypertensis Colitis, and History of Medical record review dated May 12, 2011 or revealed, "Diet: Repleasure eatingTub the nutritional tube fer hour)"  Medical record review May 21, 2011, revealed host of shift d/t (due of host of shift d/t (due of high and scopic gastrostor Junable to unclog tube hift4:30 p (p.m.)F ont (continue) to obsolute ledical record review lay 22, 2011, revealed hat the cord review hay 24, 2011, revealed hat the cord review hat the	die	F 157		eted an in- on of oral Nurses on until all rvice. All as of June oe allowed ation is  conducted Unit wing the ID al a on and n DON, fy the cation I nurse.	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEL AID SERVICES

STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	I/vov.	II II TID. =	OMB I	VO. 0938-039
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		445303	B. WI	NG		
	PROVIDER OR SUPPLIER S HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZI 3382 ANDERSONVILLE HIGHW	P CODE	5/25/2011
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ANDERSONVILLE, TN 3770	)5	
PRÉFIX TAG	(CACIT DEFICIENCE	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE	(X5) COMPLETION DATE
F 157	I Tolli pa	age 2	F 1	57 HOW WILL THE FACI	LITY	
F 279	Medical record revienote dated May 24, nurse to eval. Pt. (p J-tubeMultiple staclear the obstruction (named) ER (emerg (gastrointestinal) lab special procedurestomorrow"  Interview on May 25. Director of Nursing, confirmed the physic the obstructed J-tube	ew of the physician's progress 2011, revealed, "Asked by atient) for obstructed ff members have attempted to a to no availcontacted gency room (and) GI o (and) was told to contactscheduled pt for 1 pm  2011, at 8:10 a.m., with the in the conference room, cian was not notified timely of e.	2	MONITOR ITS CORREACTIONS TO ENSURE DEFICIENT PRACTICE RECUR?  The DON or Unit Manager if the system is working we results of the weekly randown Change in Clinical conditionare identified then modificate identified then modificate with the QAA commit committee will review the monthly for 3 months.	THAT THE E WILL NOT  rs to determine ill review om audits of ons. If issues ation will be tee. The OAA	
SS=D	483.20(d), 483.20(k) COMPREHENSIVE	CARE PLANS	F 27	F279		6/24/11
	comprehensive plan of The facility must developlan for each resident objectives and timetal medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's		HOW WILL CORRECT BE ACCOMPLISHED RESIDENTS FOUND TO BEEN AFFECTED BY DEFICIENCT PRACTION OF THE PRACTICAL OF THE PRACTION OF THE PRACTICAL OF THE	FOR THOSE TO HAVE THE ICE?	, , , , , ,
T to h	The care plan must de be furnished to attain ighest practicable physychosocial well-being 483.25; and any service required under §483 are to the resident's expense to the resident to the residen	escribe the services that are in or maintain the resident's		Manager on June 3, 2011 Braden Scale, Pre-Physica Resident Transfer, Pain, F Bowel and Bladder. His C updated on June 3, 2011 b Manager to include his cur needs.	to include all restraint, all risk and Care plan was	

# DEPARTMENT OF HEALTH AND FOUNDAMENT OF HEALTH OF HEALTH OF HEALTH OF HE

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB N	0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	SURVEY
			A. RUILDII	NG	COMP	LETED
		445303	B. WING _			
NAME OF	PROVIDER OR SUPPLIER				05/	25/2011
NORRIS	HEALTH AND REHA	ABILITATION CENTER	3	REET ADDRESS, CITY, STATE, ZIP CODE 382 ANDERSONVILLE HIGHWAY	•	
			A	ANDERSONVILLE, TN 37705		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORR	ECTION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	JOIN D DE	COMPLETION DATE
F 279	Continued From pa	age 3				1
į	under §483.10(b)(4	1)	F 279	HOW WILL THE FACILI	ГҮ	
	3 .00.10(b)(2	1).		IDENTIFY OTHER RESID	ENTS	
		***************************************		HAVING THE POTENTIA	L TO RE	
	This REQUIREMEN	NT is not met as evidenced	1	AFFECTED BY THE SAM	E	
	Uy.			DEFICIENT PRACTICE?		
	Based on medical	record review, observation,		All residents have the		
	and interview the la	CIIIV failed to review and	į	All residents have the potentia affected by this practice.	I to be	
	revise a comprehen	ISIVE plan of care to		affected by this practice.		
100	residents medical a	nd nilreing poods for an-		The facility has 4 hallows		M
	resident (#4) of nine	eteen residents reviewed.	ĺ	The facility has 4 hallways- earesidents residing on one partic	ch week the	
1				will be reviewed to ensure Car	cular hall	
	The findings include	ed:		current to the resident needs. (	e Plans are	
	Posidont #4			hallway will be reviewed week	one	1
	Resident #4 was ad	mitted to the facility	1	entire facility has been reviewe	ly until the	
1 -	Traumatic Broin Iniu	with diagnoses including	ľ	has been reviewe	d.	
- 1	Failure Chronic And	ry, Chronic Respiratory				
1	Failure, Chronic Ane	ellia, Contractures,	1	WHAT MEASURES WILL I	RE PUT	
li	imbs and usually the	plegia (paralysis of all four	ĺ	INTO PLACE OR SYSTEMI	C	1
(	percutaneous endos	scopic gastrostomy tube,		CHANGES MADE TO ENSI	RE	- 1
f	eeding tube), Pressi	ire Sores and	1	THAT THE DEFICIENT PR	ACTICE	1
1	racheostomy (surgineck for breathing).	cally created airway in the		WILL NOT RECUR?	TerreE	
1	cor for breathing).			The Licensed Nurses were in-se	ryigad by	
N	ledical record review	v of the Mini		the DON on 6/1 and 6/2/11 rega	rding the	
d	ated May 13 2011	v of the Minimum Data Set		Care Plan process and document	ina	1
s	peech, had severely	revealed the resident had no impaired cognitive skills,	1	appropriate interventions that sur	port the	1
h	ad five ongoing pres	sure sores, and was totally	1	needs for those particular resider	oport the	1
de	ependent on staff for	r all activities of daily living.	1			
i		an activities of daily living.		The MDS nurses were in-service	d on June	
M	edical record review	of the Care Plan dated	-	3, 2011 by the Regional MDS nu	rco	1
141	ay 13, 40 H. reveale	d "At Rick for Eluid Deficit		regarding Care Plan process bein	g specific	
1 ***	i acc nulus at bedst	DE IN resident's		for the residents needs.		
16	achPain/Discomfo	rt will verhally express			i	
1110	reased Salislaction	With nain control booth		MDS nurses, DON or Unit Manag	ers will	
1116	anticharice altered	Keen items in roach and	N.	audit up to 5 resident each week ti	mes 4	
rei	mind res (resident) o	of placement of objects"	Î	weeks then monthly times 2 month	es to	1
	· · · · · · · · · · · · · · · · · · ·			determine if the appropriate Care	Plans	1
			7	are in place.		1

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEL AID SERVICES

NAME OF PROVIDER OR SUPPLIER  NORRIS HEALTH AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR IS STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCY STATEMENT OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORPECTIVE ACTION OF CORRECTION (X5))		STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	()(0) 1		OMB NO	0.0938-039
NORRIS HEALTH AND REHABILITATION CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUTS OF REFORM)   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUTS) OF REFORM NORRISH (EACH DEFICIENCY NORTH APPROPRIATE DEFICIENCY PRACTICE WILL NOT RECURY.    F 279		I AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	The second		(X3) DATE	SURVEY
NORRIS HEALTH AND REHABILITATION CENTER    SUMMARY STATEMENT OF DEFICIENCIES 2382 ANDERSONVILLE HIGHWAY ANDERSONVILLE HIGHWAY ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705   PREVIOUS SUMMARY STATEMENT OF DEFICIENCIES (PARTIEVING INFORMATION)   PREFIX TAG   PREVIOUS SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY TO SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY TO SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY TO SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY TO SUMMARY STATEMENT OF DEFICIENCY PROPERTY COMPLETED TO THE APPROPRIATE COMPLETED OF THE APPROPRIATE COMPLETED TO THE APPROPRIATE COMPLETED OF				445303	B. WIN	IG	į.	
NORRIS HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES PREFEX SUMMARY STATEMENT OF DEFICIENCIES FOOD EFFORMY MUST BE PRECEDED BY FULL REGULATORY OR LSC INEMTRYNIA INFORMATION)  F 279  Continued From page 4 Observation on May 24, 2011, at 8:55 a.m., revealed the resident resting on the right side non-responsive to voice, with tube feeding infusing through a PEG tube, oxygen provided through a tracheostomy site, unrinary catheter, and contracted legs, arms, and hands.  Interview with the Director of Nursing, in the conference room, May 25, 2011, at 8:05 a.m., confirmed the current care plan had not been reviewed and revised to reflect the resident's current assessment and to meet the resident's current assessment and to meet the resident's course assessment and to meet the resident's incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	I	NAME OF	PROVIDER OR SUPPLIER				05/:	25/2011
F 279 Continued From page 4 Observation on May 24, 2011, at 8:55 a.m., revealed the resident resting on the right side non-responsive to voice, with tube feeding infusing through a PEG tube, oxygen provided through at tracheostomy site, unrinary catheter, and contracted legs, arms, and hands.  Interview with the Director of Nursing, in the conference room, May 25, 2011, at 8:05 a.m., confirmed the current care plan had not been reviewed and revised to reflect the resident's needs.  F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  P 279  HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTION To ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR?  Results of the 5 random audits will be presented to the monthly QAA committee for review. If identified issues are determined then adjustments to the plan of correction will be made.  QAA committee will monitor this for 3 months or longer depending if this plan is successful.  F 280  HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED For THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?  Resident #15 was re assessed by the FNP on May 25, 2011 and the Fluid restrictions was discontinued.		NORRIS	S HEALTH AND REHA	SILITATION CENTER		3382 ANDERSONVILLE HIGHWAY		
F 279 Continued From page 4 Observation on May 24, 2011, at 8:55 a.m., revealed the resident resting on the right side non-responsive to voice, with tube feeding infusing through a PEG tube, oxygen provided through a tracheostomy site, unrinary catheter, and contracted legs, arms, and hands.  Interview with the Director of Nursing, in the conference room, May 25, 2011, at 8:05 a.m., confirmed the current care plan had not been reviewed and revised to reflect the resident's each sasessment and to meet the resident's needs.  F 280 A83.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, the resident's find disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			SUMMARY STA	TEMENT OF DEFICIENCIES				
Observation on May 24, 2011, at 8:55 a.m., revealed the resident resting on the right side non-responsive to voice, with tube feeding infusing through a PEG tube, oxygen provided through a tracheostomy site, unrinary catheter, and contracted legs, arms, and hands.  Interview with the Director of Nursing, in the conference room, May 25, 2011, at 8:05 a.m., confirmed the current care plan had not been reviewed and revised to reflect the resident's needs.  F 280			(CACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE AP	HOLLIDBE	COMPLETION
		F 280 SS=D	Observation on May revealed the resider non-responsive to verifusing through a P through a tracheostic and contracted legs, Interview with the Director of the conference room, May confirmed the current reviewed and revised current assessment an eeds.  483.20(d)(3), 483.10(PARTICIPATE PLANTICIPATE IN	24, 2011, at 8:55 a.m., at resting on the right side bice, with tube feeding EG tube, oxygen provided omy site, unrinary catheter, arms, and hands.  Tector of Nursing, in the ay 25, 2011, at 8:05 a.m., at care plan had not been at to reflect the resident's and to meet the resident's and to meet the resident's and to meet the sident's and to meet the sident's and to meet the sident's are found to be as a laws of the State, to a care and treatment or reatment.  The plan must be developed completion of the sment; prepared by an that includes the attending nurse with responsibility ther appropriate staff in the developed sident's needs, ticable, the participation of ant's family or the resident's and periodically reviewed.		HOW WILL THE FACILITY MONITOR ITS CORRECT ACTIONS TO ENSURE TH DEFICIENT PRACTICE V RECUR?  Results of the 5 random audits presented to the monthly QAA for review. If identified issues determined then adjustments to correction will be made.  QAA committee will monitor to months or longer depending if successful.  F280  HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO HA BEEN AFFECTED BY THE DEFICIENCT PRACTICE?  Resident #15 was re assessed by on May 25, 2011 and the Fluid to was discontinued.  HOW WILL THE FACILITY IDENTIFY OTHER RESIDED HAVING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE?  Residents who require fluid restribate the potential to be affected.	ACTION THOSE ACTIONS TO BE	9/24/11

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/27/2011 CENTERS FOR MEDICARE & MED. FORM APPROVED D SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445303 NAME OF PROVIDER OR SUPPLIER 05/25/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NORRIS HEALTH AND REHABILITATION CENTER 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 | Continued From page 5 The facility currently has 4 residents on F 280 This REQUIREMENT is not met as evidenced fluid restrictions. Those residents have by: parameters in place to reflect the current Based on medical record review and interview, MD orders and Intake is being monitored. the facility failed to develop the care plan to include fluid restrictions for one (#15) of nineteen WHAT MEASURES WILL BE PUT residents reviewed. INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE The findings included: THAT THE DEFICIENT PRACTICE WILL NOT RECUR? Resident #15 was admitted to the facility on May 13, 2011, with diagnoses including End Stage The RD, DON, ADON and Unit Renal Disease, Diabetes, Cerebrovascular Managers were in-serviced by the Accident with Left Hemiparesis, and Congestive Administrator on 6/6/2011 regarding the Heart Failure. expectations of having care plans in place for fluid restrictions, Intake being Medical record review of a Nurse Practitioner's monitored. (NP) order dated May 20, 2011, revealed "...Fluid restriction 1000 cc/day..." The Licensed Nurses and Resident Care Specialist (nursing assistants) were in-Medical record review of the Interim Care Plan serviced by the DON on June 1-2, 2011 dated May 13, 2011, revealed no documentation and ongoing until all have completed the to address the resident's need for fluid restriction. in-service education regarding the facility protocol for residents with fluid Interview on May 24, 2011, at 3:25 p.m., with restrictions. This in-service education Certified Nursing Assistant (CNA) #1 (CNA will continue until we complete the inresponsible for the resident's care), at the nursing service for all Licensed Nurses and station, revealed CNA #1 was not aware of the Nursing Assistants. resident's need for fluid restriction.

include the fluid restriction.

SS=D PROFESSIONAL STANDARDS

Interview on May 24, 2011, at 4:30 p.m., with the

Director of Nursing (DON), in the DON's office,

The services provided or arranged by the facility

must meet professional standards of quality.

confirmed the care plan was not developed to

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET

utilize.

F 281

Calculations for the residents with fluid

restrictions were completed by the DON

involves the amount of fluid to be served

during each meal tray, each med pass and

ADL Kardex for the nursing assistants to

on May 24, 2011. This calculation

the available fluid for each shift. The fluid calculations were added to the

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & ME PRINTED: 05/27/20 AID SERVICES STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-035 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445303 NAME OF PROVIDER OR SUPPLIER 05/25/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NORRIS HEALTH AND REHABILITATION CENTER 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 280 | Continued From page 5 This REQUIREMENT is not met as evidenced F 280 Intake records were implemented on May by: 24, 2011 for the residents identified with Based on medical record review and interview, fluid restrictions. the facility failed to develop the care plan to include fluid restrictions for one (#15) of nineteen A weekly audit by the DON, RD or Unit residents reviewed. Managers for the residents with fluid restrictions will be completed for 4 weeks The findings included: then 2 months to determine if the MD orders are being followed and included on Resident #15 was admitted to the facility on May the ADL kardex. 13, 2011, with diagnoses including End Stage Renal Disease, Diabetes, Cerebrovascular HOW WILL THE FACILITY Accident with Left Hemiparesis, and Congestive MONITOR ITS CORRECTIVE Heart Failure. ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT Medical record review of a Nurse Practitioner's RECUR? (NP) order dated May 20, 2011, revealed "...Fluid restriction 1000 cc/day...' The RD, Unit managers and the DON will present the results of the audits to the Medical record review of the Interim Care Plan QAA committee for 3 months. If issues dated May 13, 2011, revealed no documentation are identified then modifications to the to address the resident's need for fluid restriction. plan of correction will be made. Interview on May 24, 2011, at 3:25 p.m., with Certified Nursing Assistant (CNA) #1 (CNA responsible for the resident's care), at the nursing station, revealed CNA #1 was not aware of the resident's need for fluid restriction. F281 Interview on May 24, 2011, at 4:30 p.m., with the HOW WILL CORRECTIVE ACTION Director of Nursing (DON), in the DON's office, BE ACCOMPLISHED FOR THOSE

include the fluid restriction.

SS=D PROFESSIONAL STANDARDS

confirmed the care plan was not developed to

483.20(k)(3)(i) SERVICES PROVIDED MEET

The services provided or arranged by the facility

must meet professional standards of quality.

F 281

RESIDENTS FOUND TO HAVE

Resident #15 was re assessed by the FNP

on May 25, 2011 and the Fluid restrictions

BEEN AFFECTED BY THE

DEFICIENCT PRACTICE?

was discontinued.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED. ...ID SERVICES

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDEDICUES				OMB N	O. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE	
		445303	B. WIN	1G			
NAME OF	PROVIDER OR SUPPLIER						25/2011
		ABILITATION CENTER		331	EET ADDRESS, CITY, STATE, ZIP CODE 82 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705	≣	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	! ID				
PREFIX TAG	(EACH DEFICIENT	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOLLD BE	COMPLETION DATE
F 281	by: Based on medical	NT is not met as evidenced	F 2	81	HOW WILL THE FACILI IDENTIFY OTHER RESII HAVING THE POTENTIA AFFECTED BY THE SAM DEFICIENT PRACTICE?	DENTS AL TO BE	
o p the to d	Nurse Practitioner	ew, the facility failed to follow s orders for a fluid restriction deteen residents reviewed.			Residents who require fluid re have the potential to be affect practice.	estrictions ed by this	
	Renal Disease, Dia Accident with Left Heart Failure.  Medical record reviews	admitted to the facility on May noses including End Stage betes, Cerebrovascular demiparesis, and Congestive ew of a Nurse Practitioner's ay 20, 2011, revealed "Fluid"			The facility currently has 4 refluid restrictions. Those resid parameters in place to reflect to MD orders and Intake is being WHAT MEASURES WILL INTO PLACE OR SYSTEM CHANGES MADE TO ENSTHAT THE DEFICIENT PROBLEM OF THE NOT RECUR?	ents have the current the current the monitored.  BE PUT HIC URE	
	Review of the facility evealed "Purpose-T luid restrictions receillocationFluid restrictions of the facility evealed "Purpose-T luid restrictions receillocationFluid restrictionsFluid restrictionsFluid restrictionsFluid restrictionsFluid restrictionsFluid sectionsFluid to comply with the complete that the fluid that will be expartmentThe fluid edietary software, in	trictions are coordinated partment and Nursing beverage preferences are with fluid restriction physician ation of a fluid restriction Dietary Manager meets with determine the amount of			The RD, DON, ADON and Un Managers were in-serviced by Administrator on 6/3/2011 regard expectations of having care platfor fluid restrictions, Intake beimonitored.  The Licensed Nurses and Reside Specialist (nursing assistants) was reviced by the DON on June 1 and is ongoing until all have counte in-service education. regard facility protocol for residents was restrictions. This in-service education will continue until we complete service for all Licensed Nurses and Nursing Assistants.	lent Care vere in2, 2011 mpleted ing the ith fluid ication the in-	

### DEPARTMENT OF HEALTH AND HI MAN SERVICES CENTERS FOR MEDICARE & MEL ID SERVICES

STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(٧0) 1411	I TIPLE COMPANY	OWR MC	<u>). 0938-039</u>
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		445303	B. WING			
	F PROVIDER OR SUPPLIER  IS HEALTH AND REHAL	BILITATION CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY	05/2	25/2011
(X4) ID	STIMMADY STA			ANDERSONVILLE, TN 37705		
PREFI) TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOLLI D. BE	(X5) COMPLETION DATE
F 282 SS=D	responsible for the ristation, revealed CN resident's need for fl Interview and review tray tickets, on May 2 the Registered Dietic nursing station, rever fluid restriction on the ticket, and confirmed unaware of the order Interview on May 25, Director of Nursing (Interview on May	pe served."  1, 2011, at 3:25 p.m., with sistant (CNA) #1 (CNA) esident's care), at the nursing A #1 was not aware of the uid restriction.  1, 2011, at 4:15 p.m., with sian (RD), at the 400 hall aled no documentation of the exercident's current tray the dietary department was for the fluid restriction.  1, at 8:40 a.m., with the DON), in the office, revealed entation of the resident's total remed the NP's orders were CES BY QUALIFIED E PLAN  1, or arranged by the facility qualified persons in resident's written plan of the is not met as evidenced ord review and interview, by the care plan developed.	F 282	The DON on May 24, 2011cd calculations for the residents restrictions. This calculation amount of fluid to be served of meal tray, each med pass and a fluid for each shift.  The fluid calculations were ad ADL Kardex for the nursing at utilize.  Intake records were implement 24, 2011 for the residents identifluid restrictions.  A weekly audit by the DON, R Managers for the residents with restrictions will be completed for them 2 months to determine if the dorders are being followed and in the ADL kardex.  HOW WILL THE FACILITY MONITOR ITS CORRECTIVACTIONS TO ENSURE THAT DEFICIENT PRACTICE WIRECUR?  The RD, Unit managers and the present the results of the audits of QAA committee for 3 months. are identified then modifications plan of correction will be made.	with fluid involves the luring each the available ded to the ssistants to led on May diffied with led or Unit of fluid for 4 weeks the MD included on led on	
	go moladed.	i i				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & M PRINTED: 05/27/2 CAID SERVICES STATEMENT OF DEFICIENCIES FORM APPROV (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0; (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445303 NAME OF PROVIDER OR SUPPLIER 05/25/2011 NORRIS HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETIO CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282: Continued From page 8 F 282 F282 6/24/11 Resident #4 was admitted to the facility December 17, 2010 with diagnoses including HOW WILL CORRECTIVE ACTION Traumatic Brain Injury, Chronic Respiratory BE ACCOMPLISHED FOR THOSE Failure, Chronic Anemia, Contractures, RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE Malnutrition, Quadriplegia (paralysis of all four limbs and usually the trunk), Peg Tube DEFICIENCT PRACTICE? (percutaneous endoscopic gastrostomy tube, Resident #4 has had his care plan updated feeding tube), Pressure Sores, and to reflect no Intake & output. On June 3, Tracheostomy (surgically created airway in the 2011 by the Unit Manager. neck for breathing). Medical Record review of the resident's Plan of Care dated May 13, 2011, revealed "...At Risk for HOW WILL THE FACILITY Fluid Deficit...Approach...Intake and output q IDENTIFY OTHER RESIDENTS (every) shift...". Further medical record review of HAVING THE POTENTIAL TO BE Medication Administration Records and resident's AFFECTED BY THE SAME chart revealed no documentation of fluid intake DEFICIENT PRACTICE? and output monitoring Residents who have Enteral feedings have Interview with the Director of Nursing in the the potential to be affected by this conference room on May 25, 2011, at 8:05 a.m., practice. confirmed the facility staff had not monitored fluid intake and output for the resident per the current The facility currently has 12 residents with enteral feedings. These residents Plan of Care. F 315 483.25(d) NO CATHETER, PREVENT UTI, care plans were reviewed to ensure the SS=D RESTORE BLADDER Care Plan is appropriate for the F 315 interventions being provided. Based on the resident's comprehensive assessment, the facility must ensure that a The facility currently has 1 resident resident who enters the facility without an requiring Intake and Output. indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that

function as possible.

catheterization was necessary; and a resident

treatment and services to prevent urinary tract

who is incontinent of bladder receives appropriate

infections and to restore as much normal bladder

WHAT MEASURES WILL BE PUT

THAT THE DEFICIENT PRACTICE

INTO PLACE OR SYSTEMIC

WILL NOT RECUR?

CHANGES MADE TO ENSURE

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/27/2011 CENTERS FOR MEDICARE & MED FORM APPROVED JD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445303 05/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORRIS HEALTH AND REHABILITATION CENTER 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 282: Continued From page 8 F 282 Licensed nurses were in-serviced on June 1-2, 2011 and Ongoing until all are Resident #4 was admitted to the facility completed by the DON regarding the need December 17, 2010 with diagnoses including to complete Intake and Output for those Traumatic Brain Injury, Chronic Respiratory residents identified as well as the need to Failure, Chronic Anemia, Contractures, review the care plans for residents to Malnutrition, Quadriplegia (paralysis of all four include appropriate interventions for each limbs and usually the trunk), Peg Tube resident (if resident is bed bound- not (percutaneous endoscopic gastrostomy tube, include items to be placed in reach, if on feeding tube), Pressure Sores, and fluid restriction- not to include place Tracheostomy (surgically created airway in the water pitcher at bedside) neck for breathing). MDS nurses and the DON, ADON and Medical Record review of the resident's Plan of Unit Managers were in-serviced on June Care dated May 13, 2011, revealed "...At Risk for 3, 2011 by the Administrator regarding Fluid Deficit...Approach...Intake and output q (every) shift...". Further medical record review of the implementations of appropriate Medication Administration Records and resident's interventions such as items being in reach chart revealed no documentation of fluid intake for residents that are able to reach and and output monitoring obtain those items. Interview with the Director of Nursing in the The DON, ADON, Unit Managers and the conference room on May 25, 2011, at 8:05 a.m., MDS nurses will audit 5 charts weeks to confirmed the facility staff had not monitored fluid determine if the interventions are intake and output for the resident per the current appropriate for the resident. These audits Plan of Care. will occur for 4 weeks then monthly for 2 F 315 483.25(d) NO CATHETER, PREVENT UTI, months. F 315 SS=D RESTORE BLADDER HOW WILL THE FACILITY Based on the resident's comprehensive MONITOR ITS CORRECTIVE assessment, the facility must ensure that a ACTIONS TO ENSURE THAT THE resident who enters the facility without an DEFICIENT PRACTICE WILL NOT indwelling catheter is not catheterized unless the RECUR?

function as possible.

resident's clinical condition demonstrates that catheterization was necessary; and a resident

treatment and services to prevent urinary tract

who is incontinent of bladder receives appropriate

infections and to restore as much normal bladder

continue.

Results of the audits will be presented to

modifications will be made and audits will

the monthly QAA committee for 3

months. If issues are identified then

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & M CAID SERVICES

PRINTED: 05/27/2

AND PLAN	NT OF DEFICENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA	Taur		FOR OMB N	M APPROV O. 0938-03
	o o medion	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE	SURVEY
NAME OF	DDO://DDD	445303	1	NG	COMP	CELED
	PROVIDER CR SUPPLIER			STREET ADDRESS CITY OTHER	05/	25/2011
HORRIS	HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3382 ANDERSONVILLE HIGHWAY	DDE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		ANDERSONVILLE, TN 37705		
TAG	REGULATORY OR L	MOST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLETIO DATE
F 315	Continued From pag	ge 9	F3	F215		6/200
F 1 S C M da re sh mo	Based on medical reand interview, the factor for the continuation for the continuation for the continuation for one (#14 reviewed.  The findings included Resident #14 was admarated admarated and History of dedical record review attention for the finding form (as need for the continuation on May 25 realed the resident to the finding for the continuation on May 25 realed the resident to the finding for the continuation on May 25 realed the resident to the continuation on May 25 realed the resident to the continuation on May 25 realed the resident to the continuation on May 25 realed the resident to the continuation on May 25 realed the resident to the continuation on May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of May 25 realed the resident to the continuation of the continua	mitted to the facility on May ses including Aortic n, Diabetes, Ulcerative Bowel Resection.  of the physician's orders arough May 31, 2011, ry catheter) care q (every) ded) (change) F/C q		HOW WILL CORRECT BE ACCOMPLISHED FO RESIDENTS FOUND TO BEEN AFFECTED BY THE SAME DEFICIENCY PRACTIC  Resident #14- Was reviewed Medical Director and a new to include Neurogenic Bladds to extensive abdominal survey incomplete bladder emptying Resident #14 is no longer a resolution Norris Health and Rehab.  HOW WILL THE FACILI' IDENTIFY OTHER RESID HAVING THE POTENTIA AFFECTED BY THE SAME DEFICIENT PRACTICE?  The residents currently utilizing catheters are at risk for this practice.	OR THOSE HAVE HE E? I by the Dx was added der secondary ey causing g. esident at TY DENTS L TO BE	924)1
Inte Nur con the 371 483 SED STO	erview on May 25, 20	11, at 8:35 a.m., with the conference room, medical justification for urinary catheter.	F 371	The facility currently has 7 resutilizing urinary catheters. All residents have been evaluated t determine if the appropriate me justification is in place.  WHAT MEASURES WILL BINTO PLACE OR SYSTEMIC CHANGES MADE TO ENSUFTHAT THE DEFICIENT PRA	these o edical	

# DEPARTMENT OF HEALTH AND HIMAN SERVICES CENTERS FOR MEDICARE & MED .ID SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MUL.	TIPLE CONSTRUCTION		0. 0938-039
		IDENTIFICATION NUMBER:	A. BU			(X3) DATE S	
		445303	B. WII	NG_			
NAME OF	PROVIDER OR SUPPLIER			CT	TOTAL ADDRESS	05/2	25/2011
NORRI	S HEALTH AND REHAE	BILITATION CENTER		3	REET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	-	<u>_</u>	ANDERSONVILLE, TN 37705		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LIDRE	(X5) COMPLETION DATE
	Based on medical reand interview, the fact justification for the concatheter for one (#14 reviewed.  The findings included Resident #14 was ad 12, 2011, with diagnostenosis, Hypertensic Colitis, and History of Medical record review dated May 12, 2011, to	T is not met as evidenced ecord review, observation, cility failed to ensure medical ontinued use of a urinary of nineteen residents.  I:  mitted to the facility on May ses including Aortic on, Diabetes, Ulcerative Bowel Resection.  of the physician's orders hrough May 31, 2011, ary catheter) care g (event)	F3	315	,	Ill are leed to arinary lion for the lers were on the Clinical leed with medical lf no D must be necessity less then N,	
F 371 4 SS=D 5	Observation on May 25, 2011, at 7:45 a.m., revealed the resident lying on the bed with a urinary catheter to a bedside drainage bag.  Interview on May 25, 2011, at 8:35 a.m., with the Nurse Practitioner, in the conference room, confirmed there was no medical justification for the continued use of the urinary catheter.  483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must -  1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and		F 371		catheters occur each week) to determ the medical justification for the cather are in place. If the medical justification in place then the MD will be cand appropriate interventions to act the issues identified will occur.  HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT DEFICIENT PRACTICE WILL RECUR?  Results of the random audits will be presented to the monthly QAA comfor 3 months. If identified issues an noted then modifications to this place correction will be made.	ermine if atheters cation is consulted ddress  THE NOT	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & ME. AID SERVICES

PRINTED: 05/27/201 FORM APPROVE

AND PLAN OF CORRECTION  A45303  NAME OF PROVIDER OR SUPPLIER  NORRIS HEALTH AND REHABILITATION CENTER  SIZE ADDRESS, CITY, STATE, ZIP CODE 332 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TI 37705  SUMMANY STATEMENT OF DEFICIENCIES  EACH OPERIOD BY FULL TAG  TAG  COntinued From page 10 (2) Store, prepare, distribute and serve food under sanitary conditions  F 371  Continued From page 10 (2) Store, prepare, distribute and serve food under sanitary conditions  F 371  This REQUIREMENT is not met as evidenced by: Based on observation, facility folicy review, and interview, the facility failed to folicw proper hand-washing, and sanitary food preparation and storage to maintain safe food handling practices.  The findings included:  Observation on May 23, 2011, during the initial tour, beginning at 6.04 a.m., with the facility cook, in the dietary department, revealed the following:  The cook went to the hand-washing station, in the kitchen, washed the hands, and found the paper towel dispenser empty. The cook proceeded through the kitchen, fanning the hands to dry. The cook requested housekeeping refill the paper towel dispenser had been filled.  Review of the facility's food handling policy revealed" 2 Practice good personal hygienewash hands regularly and dry with paper towels  Interview with the cook, at the time of the observation, confirmed that the facility's hand washing policy had not been followed.  A BUILONG  STREET ADDRESS, CITY, STATE, ZIP CODE 332 ANDERSONVILLE HIGHWAY ANDERSONVILL	I	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Turan nu		OMB NO	D. 0938-039
NORRIS HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCES  PROVIDERS ONLILLE, TN 37703  PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (2) Store, prepare, distribute and serve food under sanitary conditions  F 371  This REQUIREMENT is not met as evidenced by:  Based on observation, facility policy review, and interview, the facility failed to follow proper hand-washing, and sanitary food preparation and storage to maintain safe food handling practices.  The findings included:  Observation on May 23, 2011, during the initial tour, beginning at 6:04 a.m., with the facility cook, in the dietary department, revealed the following:  The cook went to the hand-washing station, in the kitchen, washed the hands, and found the paper towel dispenser empty. The cook proceeded through the kitchen, fanning the hands to dry. The cook requested housekeeping refill the paper towel dispenser hand been filled.  Revisew of the facility's food handling policy revealed"2. Practice good personal hyglenewash hands regularlyand dry with paper towels*  Interview with the cook, at the time of the observation, confirmed that the facility's hand washing policy had not been followed.		AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	The second second		(X3) DATE	SURVEY
NORRIS HEALTH AND REHABILITATION CENTER    SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTIVE ACTION   PREFIX   REGULATION OR LISC IDENTIFYING INFORMATION)   PREFIX   PROVIDERS PLAN OF CORRECTIVE ACTION   DEFICIENCY   PREFIX   PROVIDERS PLAN OF CORRECTIVE ACTION   DEFICIENCY   PREFIX   PROVIDERS PLAN OF CORRECTIVE ACTION   DEFICIENCY   PROVIDERS PLAN OF CORRECTION SHOULD BE COMPACTIVE   CO	ŀ	NAME		445303	B. WINC	3	0.54	0.5/0.5
(2) Store, prepare, distribute and serve food under sanitary conditions  HOW WILL CORRECTIVE ACTION BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENCT PRACTICE?  This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow proper hand-washing, and sanitary food preparation and storage to maintain safe food handling practices.  The findings included:  The findings included:  The findings included:  The cook went to the hand-washing station, in the kitchen, washed the hand-washing station, in the kitchen, washed the hand-washing station, in the kitchen, washed the hands and found the paper towel dispenser empty. The cook proceeded through the kitchen, fanning the hands to dy. The cook requested housekeeping refill the paper towel dispenser. The cook did not return to the sink to properly re-wash the hands after paper towel dispenser had been filled.  Review of the facility's food handling policy revealed"2 Practice good personal hygienewash hands regularlyand dry with paper towels"  Interview with the cook, at the time of the observation, confirmed that the facility's hand washing policy had not been followed.		NORRIS (X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX	ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705  PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	RECTION	(X5) COMPLETION
		In to both the control of the contro	(2) Store, prepare, dunder sanitary conditions and sanitary conditions and sanitary conditions are considered as a sanitary conditions and sanitary and sanitary conditions are considered as a condition and conditions are conditional conditions and conditions are conditional conditions are conditional conditions. The condition are conditional conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditional conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions. The conditions are conditional conditions are conditional conditions are conditional conditions are conditional conditions. The	istribute and serve food tions  T is not met as evidenced on, facility policy review, and failed to follow proper anitary food preparation and afe food handling practices.  23, 2011, during the initial 4 a.m., with the facility cook, ent, revealed the following:  hand-washing station, in the ands, and found the paper of the cook proceeded nning the hands to dry. The keeping refill the paper cook did not return to the ship the hands after paper een filled.  food handling policy good personal regularlyand dry with	F 37	HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO BEEN AFFECTED BY THE DEFICIENCT PRACTICE.  The Dietary staff has all been on proper hand washing technologies were replaced in the discussion of the plastic bins have been orded by June 3, 2011 to replace the one inappropriate fitting lids.  The ham and Tofu were throw HOW WILL THE FACILIT IDENTIFY OTHER RESIDING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE?  Any area within the facility has potential for paper towels not to place.  WHAT MEASURES WILL BINTO PLACE OR SYSTEMIC CHANGES MADE TO ENSUTHAT THE DEFICIENT PRACTICE?  The Dietary staff was in-serviced proper hand washing technique of the proper h	R THOSE HAVE E ? in-serviced nique. Paper ispenser. loths were propriate lered on es with n out. Y ENTS TO BE the be in E PUT C RE ACTICE	6/24/11

#### DEPARTMENT OF HEALTH AND HIMAN SERVICES PRINTED: 05/27/2011 CENTERS FOR MEDICARE & MED ID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445303 05/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORRIS HEALTH AND REHABILITATION CENTER 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 371 | Continued From page 11 F 371 The dietary staff was in-serviced on Continued observation of the dietary department, proper storage of cleaning cloths and during initial tour on May 23, 2011, revealed the scouring pads on May 31, 2011 and June following: 3, 2011 by the Dietary Manager. Scouring pads and cleansing cloths stored on a food prep table where toast was being prepared The dietary staff was in-serviced on for breakfast. dating food placed in the refrigerator on Plastic bins, used for storage of dry beans, May 31, 2011 and June 3, 2011 by the dry cereal, and sugar with lids that did not fit Dietary Manager. properly. 3. Plastic container with dry cereal contained A daily audit for Sanitation checklist, debris: cereal crumbs and onion peels. handwashing and storage of cleaning Red food coloring on the storage shelves supplies and equipment along with dating of food has been implemented (M-F) by without a lid. The reach in cooler in the kitchen contained: the Dietary Manager and the assistant a. ham in a small zip lock bag with no opened or manager on May 31, 2011. use by date b. tofu stored in a small plastic container with a Plastic bins have been order to replace the lid that did not close properly. ones with ill-fitting lids on June 3, 2011. Review of the facility policy for food storage HOW WILL THE FACILITY revealed"...5. Store cleaning supplies away from MONITOR ITS CORRECTIVE food storage and preparation areas...7. Store ACTIONS TO ENSURE THAT THE foods in clean, dry containers with tight fitting lids DEFICIENT PRACTICE WILL NOT to prevent contamination...6. Date and label all RECUR? products removed from original containers/packaging..." Results of the daily (M-F) audits will be presented to the QAA committee monthly Interview with the Dietary Manager, in the dietary times 3 months. If identified issues are department, on May 23, 2011, at 9:20 a.m., noted then modifications will be made to confirmed the facility policies on hand hygiene this plan of correction. and food storage had not been followed. F 372 483.35(i)(3) DISPOSE GARBAGE & REFUSE F 372 SS=B PROPERLY

properly.

The facility must dispose of garbage and refuse

# DEPARTMENT OF HEALTH AND 'MAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

SIAIEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1,000		OMB N	<u>0. 0938-039</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE	
		445303	B. WIN	G	_	
NAME OF	PROVIDER OR SUPPLIER			CYPERT	05/	25/2011
NORRIS	HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 3382 ANDERSONVILLE HIGHY	VAY	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<del></del>	ANDERSONVILLE, TN 377		
PREFIX TAG	(CAUT DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 372	Continued From pa	ge 12	F 37	F372		6/201
	This REQUIREMENT by: Based on observation failed ensure garbage disposed of. The findings include Observation of the faza, 2011, at 12:30 p. (DM), revealed the disposed including: three six plastic straws, three wrappers, two used see the six plastic straws.	on and interview the facility ge and refuse were properly d:  acility's dumpsters on May m., with the Dietary Manager umpster area with scattered e disposable latex gloves, ee plastic cups, two candy sweetener packets, and k and knife) on the ground		HOW WILL CORREBE ACCOMPOLISH RESIDENTS FOUND BEEN AFFECTED B DEFICIENCT PRAC  The debris around the Deficient and is currently  HOW WILL THE FA IDENTIFY OTHER R HAVING THE POTE AFFECTED BY THE DEFICIENT PRACTI	ED FOR THOSE TO HAVE Y THE TICE?  Dumpster was y debris free.  CILITY ESIDENTS NTIAL TO BE SAME	6/24/11
F 386 2 SS=E C	Interview with the DM observation, confirment clean and well made 183.40(b) PHYSICIAN CARE/NOTES/ORDE The physician must reprogram of care, inclusted the section; write, so the section; write, so the section of inclusive at each visit; and the exception of inclusive controlly section of inclusive controlly se	, at the time of the d the dumpster area was intained.  I VISITS - REVIEW RS  view the resident's total ding medications and sit required by paragraph (c) ign, and date progress d sign and date all orders offluenza and pneumococcal.	F 386	The Dumpsters are at rispractice.  WHAT MEASURES WINTO PLACE OR SYSCHANGES MADE TO THAT THE DEFICIENT WILL NOT RECUR?  The dietary staff was in-sally 2011 and June 3, 2011 manager regarding the neareas around the dumpste up and free of debris.	k for this  VILL BE PUT  TEMIC ENSURE  NT PRACTICE  erviced on May 1by the Dietary ed to ensure the r remains picked	
Ba	•	s not met as evidenced and review and interview, ate the May 2011,		The Dietary staff will mal of the area around the dur minimum of 3 times a day ensure the area remains fr	npsters at a	

## DEPARTMENT OF HEALTH AND 1 MAN SERVICES CENTERS FOR MEDICARE & MEL LAID SERVICES

STATEMENT OF DEFICIENCIES	(X1) BROWNER OF VICES			OMB NO	. 0938-039
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	URVEY
	445303	B. WING	3		
NAME OF PROVIDER OR SUPPLIER				05/2	5/2011
NORRIS HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
PREFIX : (EACH DEFICIENCY )	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JIII D BE	(X5) COMPLETION DATE
Based on observation failed ensure garbage disposed of.  The findings included Observation of the face 23, 2011, at 12:30 p.r. (DM), revealed the durefuse including: three six plastic straws, three wrappers, two used sy plastic utensils (a fork surrounding the dump Interview with the DM, observation, confirmed not clean and well maid 483.40(b) PHYSICIAN CARE/NOTES/ORDER The physician must rever program of care, including the dump treatments, at each vision of this section; write, signotes at each visit; and with the exception of impolysaccharide vaccine administered per physician must rever program of care, include the program of care, include th	In and interview the facility and refuse were properly and refuse a disposable latex gloves, see plastic cups, two candy weetener packets, and and knife) on the ground ster.  at the time of the distribution and the dumpster area was nationed.  VISITS - REVIEW RS  View the resident's total ling medications and it required by paragraph (c) gn, and date progress sign and date all orders fluenza and pneumococcal s, which may be chan-approved facility tent for contraindications.	F 386	An audit log of the dumpster's observation has been implement provide documentation of areas of debris.  HOW WILL THE FACILITY MONITOR ITS CORRECTI ACTIONS TO ENSURE THE DEFICIENT PRACTICE WIRECUR?  Results of the dumpster audit to presented to the QAA committee for 3 months, if identified issue then modifications will be madeplan of correction.	Y VE AT THE ILL NOT  og will be ee monthly s are noted	

# DEPARTMENT OF HEALTH AND ' MAN SERVICES CENTERS FOR MEDICARE & MEL. JAID SERVICES

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445000	B. WIN	LDING	COMP	relen	
NAME OF F	PROVIDER OR SUPPLIER	445303	J. 7711		05/	25/2011	
NORRIS	HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
F 386 SS=E T pp tr oil no we pool according to the by Ba	Based on observation failed ensure garbatisposed of.  The findings included Observation of the from th	ion and interview the facility ge and refuse were properly ed:  acility's dumpsters on May .m., with the Dietary Manager dumpster area with scattered se disposable latex gloves, ree plastic cups, two candy sweetener packets, and ik and knife) on the ground syster.  M, at the time of the ed the dumpster area was aintained.  N VISITS - REVIEW ERS  eview the resident's total adding medications and sit required by paragraph (c) sign, and date progress d sign and date all orders influenza and pneumococcal es, which may be ician-approved facility ment for contraindications.	F 386	F386	ACTION R THOSE AVE  10, 11, Monthly d these all ate.  NTS TO BE	Ce/zylo	

## DEPARTMENT OF HEALTH AND ' 'MAN SERVICES CENTERS FOR MEDICARE & MEL JAID SERVICES

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		PLE CONSTRUCTION	(X3) DATE SURVEY	
				A. BUILDING		COMPLETED	
NAME -		445303	B. WI	NG_			
	NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	05/2	25/2011
NORR	IS HEALTH AND REHAE			33	82 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	! ID	T	PROVIDER'S PLAN OF CORRE	CTION	
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOLII D DE	COMPLETION DATE
F 37	2 Continued From pag	ge 12	E 3	372			
	This REQUIREMEN	T is not met as evidenced	5	12	WHAT MEASURES WILL	BE PUT	
	by.	on and interview the facility		1	INTO PLACE OR SYSTEM CHANGES MADE TO ENS	IIC EUDE	
	failed ensure garbag			THAT THE DEFICIENT P WILL NOT RECUR?	RACTICE		
	The findings included	4.			A meeting was conducted with	) the	
					Medical Director on 5/31/201	related to	
	Observation of the fa			the deficiency cited during the survey involving the Medical	annual		
	(Divi), revealed the di	m., with the Dietary Manager umpster area with scattered			dating his orders when he sign	s them	
	refuse including: thre	e disposable latev gloves			The MD agrees to date his ord forward.	ers going	
	JIN PIASTIC STRAWS, INF	ee plastic cups, two candy weetener packets, and					
	plastic utensiis (a fork	( and knife) on the ground			A meeting with the family FNI	's was	
	surrounding the dump	oster.		1	conducted by the Administrato 31, 2011 and June 3, 2011 relat	r on May	
	Interview with the DM	, at the time of the			deficiency involving the lack of	dates for	
	observation, confirme	bservation, confirmed the dumpster area was ot clean and well maintained.			orders being provided. The FN to date their orders as well.	P's agree	
F 386	483.40(b) PHYSICIAN	I VISITS - REVIEW	<b>5</b> 00				
SS=E	CARE/NOTES/ORDE	RS	F 386	3	The Medical Records Director	vas in-	
1	The physician must re	view the resident's total			serviced by the Administrator o 2011 to observe the physician at	n June 6,	
-	program of care, include	ding medications and			physician extender orders to det	ermine if	
!	reatments, at each vis	sit required by paragraph (c)			dates are being applied to their of	orders If	
	or tries section, write, s	gn, and date progress I sign and date all orders			issues involving not dating the o observed then immediately make	rders are	
	with the exception of in	fluenza and pneumococcal			administrator aware so intervent	ions can	
4.3	polysacchanide vaccine	S Which may ha			me made to ensure the dates get orders.	applied to	
1	administered per physicolicy after an assessm	cian-approved facility nent for contraindications.		į	5.50 25 2 - <del>2</del> -		
		on dentifications.			The Medical Records Director w	ill	1
1	This REQUIREMENT i	s not met as evidenced			randomly audit the monthly reca	sheets	
L	by.		i			1	
t)	he physician failed to d	rd review and interview, ate the May 2011,					

		AND HIMAN SERVICES				FKINIEL	J: 05/2//2011
	ERS FOR MEDICARE	& MED   D SERVICES				OMB NO	M APPROVED 0. 0938-0391
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE S	SURVEY
		445303	B. WI	ING		05#	25/2244
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	05/2	25/2011
NORRI	S HEALTH AND REHAE	BILITATION CENTER			3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JI D BE	(X5) COMPLETION DATE
F 386 SS=E	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed ensure garbage and refuse were properly disposed of.  The findings included:  Observation of the facility's dumpsters on May 23, 2011, at 12:30 p.m., with the Dietary Manager (DM), revealed the dumpster area with scattered refuse including: three disposable latex gloves, six plastic straws, three plastic cups, two candy wrappers, two used sweetener packets, and plastic utensils (a fork and knife) on the ground surrounding the dumpster.  Interview with the DM, at the time of the observation, confirmed the dumpster area was not clean and well maintained.  483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS  The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility		F 386			ring each s monthly.  Y  IVE  AT THE	
	This REQUIREMENT by:	is not met as evidenced ord review and interview, date the May 2011,			identified issues are observed then QAA committee including the medirector will discuss the issues and recommendations for the issues to resolved. Modifications to this pla correct will occur if the QAA complete the processory	the dical make be n of	

deems necessary.

### DEPARTMENT OF HEALTH AND HI MAN SERVICES CENTERS FOR MEDICARE & MEL ID SERVICES

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE	SURVEY LETED
		445303	B. WIN	G	05	10E/00++
NORRIS	S HEALTH AND REHA	ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP 3382 ANDERSONVILLE HIGHWA ANDERSONVILLE, TN 37705 PROVIDER'S PLAN OF C	CODE AY 5	25/2011
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 386	#10, #11, #13, #14, residents reviewed.  The findings include	recapitulation orders when #1, #2, #3, #4, #6, #7, #8, #9, and #15) of nineteen	F 38	36		
	#2, #3, #4, #6, #7, # and #15, revealed the signed by the physic May 2011, physiciar	lation orders for residents #1, #8, #9, #10, #11, #13, #14, ne recapitulation orders were cian. Continued review of the 1's recapitulation orders cumented indicating when the				
F 511 SS=D	confirmed the physic when signed for the recapitulation orders #6, #7, #8, #9, #10, 7 483.75(k)(2)(ii) RADI	, 2011, at 10:30 a.m., with the at the nursing station, cian's signature was not dated May 2011, physician's for residents #1, #2, #3, #4, #11, #13, #14, and #15. OLOGY TLY NOTIFY PHYSICIAN	F <b>51</b> 1	F511	A.	6/24/
	The facility must prorphysician of the finding the finding that the finding that the facility failed to proper nurse practitioner of the facility failed to proper nurse nurse proper nurse	mptly notify the attending		HOW WILL CORRECT BE ACCOMPOLISHED RESIDENTS FOUND TO BEEN AFFECTED BY TO DEFICIENCT PRACTION The Chest R-ray was report physician. No other interventions can time for this issue.	FOR THOSE O HAVE THE CE? Ted to the	124/4
•	The findings included:					

### DEPARTMENT OF HEALTH AND MAN SERVICES CENTERS FOR MEDICARE & MEL, CAID SERVICES

PRINTED: 05/27/2 FORM APPROV

STATEME	INT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	lover so		OMB NO	M APPRO D. 0938-
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY	
			1		COMPL	ETED
VAME OF	PROVIDER OR SUPPLIER	445303	B. WING			
			s	STREET ADDRESS, CITY, STATE, ZIP CODE	05/2	25/2011
NORRI	S HEALTH AND REHA	BILITATION CENTER		3382 ANDERSONVILLE HIGHWAY		
(X4) ID	SUMMARY ST	TEMENT OF PERSON		ANDERSONVILLE, TN 37705		
PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC	TION	
.,,,	MEGOLATORY OR L	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR		COMPL
				DEFICIENCY)	OFRIATE	DAT
F 386	Continued From pa	ge 13	<b>-</b> 00.			
	monthly physician's	recapitulation	F 386	TOW WILL THE FACILITY	7	
	orgined for thinteen	# 1 # 2 # 3 # 4 # 6 # 7 # 6 # 6		IDENTIFY OTHER RESIDE	NTC	
	, , , , , , , , , , , , , , , , , , ,	and #15) of nineteen		HAVING THE POTENTIAL	TORE	
	residents reviewed.	,		AFFECTED BY THE SAME	- O DE	
	The findings in the			DEFICIENT PRACTICE?		
	The findings include	a:		Residents with rodial		
	Medical record revie	W of the May 2011		Residents with radiology orders for this issue.	are at risk	
	Privolciali S recanifili	ation orders for		issue.		
	"-, "0, ", "0, #/, #	N HU #10 #11 #40 #44		WHAT MEASURES WILL BI	P DUT	
	and mio, levelled in	P reconitulation and		INTO PLACE OR SYSTEMIC	PUI	
1	Significantly the Dilysic	an Continued		CHANGES MADE TO ENSUE	SE	
		S I ACONITI II Otion		THAT THE DEFICIENT PRA	CTICE	
İ	physician's orders we	Umented indicating when the		WILL NOT RECUR?	o neg	
- 1		180		The Licensed Nurses were in-serv	dood on	
	Interview on May 25,	2011, at 10:30 a.m., with the		June 1-2, 2011 and on-going until	011	
		I IDA DUrcina etat:		have completed the in-service adu	ontin-	
34 1	Sommined the physici	an's signature	1	regarding the need to include now	andana	
				to the 24 Hour Nursing report so f	ollow	
3.4	coapitulation orders i	Of regidente #1 #0 #0 #4		up can take place that include reno	orting	
4	483.75(k)(2)(ii) RADIO	#13 #14 ond #45		results of such services.		
=D F	FINDINGS-PROMPTI	LOGY LY NOTIFY PHYSICIAN	F 511	During the Dellar III		
0.5		0.33455		During the Daily clinical Meeting	the 24	
jΤ	he facility must prom	ptly notify the attending		Hour nursing report (M-F) will be reviewed by the DON, ADON and		
ļp	hysician of the finding	is.		Managers to ensure follow up on m	Unit	
!		,		procedures have taken place includ	ina	
_				MD notification.	mg	
1.	nis REQUIREMENT	is not met as evidenced				
	у.	NEW COLUMN		Copies of medical procedures inclu-	ding	
- th	e facility fair	ord review and interview,	:	labs, x-rays will also be placed on the	ne	
	- racinty falled to from	nntly notify the -b:	1	physician communication board.		
, -,	marge practitioner of	THE recults of a about			1	
10	r one (#1) of nineteen	residents reviewed.	į	An audit of 5 random medical proce	dures	
Th	e findings included:			will be reviewed from the new Teler	ahana	
1.5	aniga inicidded;		i	Orders/24 Hr Nursing report weekly	for 1	
			3	weeks then monthly for 2 months. I	f	
2.2567/0	2.001.0			identified issues are noted then	1	

#### DEPARTMENT OF HEALTH AND H' PRINTED: 05/27/2011 **IN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445303 05/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORRIS HEALTH AND REHABILITATION CENTER 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 511 Continued From page 14 F 511 appropriate interventions and in-service Resident #1 was admitted to the facility on education will be repeated for the December 31, 2010, and readmitted on April 18, involved nurse. 2011, with diagnoses including Gastrointestinal Hemorrhage, Dementia, Anemia, Osteoporosis, and Right Hip Fracture. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE Medical record review of a nursing note dated ACTIONS TO ENSURE THAT THE May 17, 2011, at 12:00 p.m., revealed "Resident DEFICIENT PRACTICE WILL NOT noted to have congestion in BLU & L (bilateral RECUR? upper and lower) lung fields per auscultation. A deep wet cough, NP (nurse practitioner) notified Results of the random audits will be new orders." presented to the QAA committee monthly for 3 months. If identified issues are Medical record review of a NP's order dated May noted then the QAA committee will make 17, 2011, revealed "CXR (chest x-ray) to r/o (rule recommendations for additional out) pneumonia..." corrections and the audits will continue until committee feels this issue is Medical record review of a chest x-ray report resolved. dated May 17, 2011, and received by the facility on May 17, 2011, revealed "...Mild patchy left basilar density compatible with pneumonia..." Medical record review revealed no documentation the physician or NP was notified of the chest x-ray results until May 20, 2011. Medical record review of a NP's order dated May 20, 2011, revealed "Levaquin (antibiotic) 500 mg (milligrams) po (by mouth) daily X (times) 10 d (days) for pneumonia." Interview on May 24, 2011, at 1:05 p.m., with the

NP/physician.

Director of Nursing, in the Administrator's office, revealed the x-ray results were to be reported to the NP/physician as soon as possible, and confirmed the three day delay in notifying the